STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
(615)532-5088, or (800)778-4123 ext. 25088
WWW.Tennessee.gov/health

BOARD FOR SOCIAL WORKERS CERTIFICATION AND LICENSURE

Dear CMSW Applicant:

In response to your request, this packet contains information relative to obtaining a certified or temporary certification as a Master Social Worker.

The requirements for application are supported by board rules and regulations and T.C.A.§63-23-101 et seq. which are included in this packet. Please read the instructions, statute, and rules and regulations carefully prior to applying. Application fees are nonrefundable and all documents submitted to the board become a part of your file and are not returnable or transferable. Individuals seeking to become licensed must hold a current Tennessee Certified Master Social Worker certificate.

It is suggested that documents listed in the instructions and checklist be requested upon receipt of the packet. The supporting documents requested in these instructions and not included with your application should be received in the board administrative office within sixty (60) days of receipt of your application.

Upon initial review of your application, if your application is incomplete or the supporting materials have not arrived in our office, a deficiency letter will be sent to you. Upon notification of a deficiency the file must be completed within sixty (60) days or the file will be closed and you will be required to reapply. When the application is deemed "administratively complete" you will be notified in writing.

PURSUANT TO RULE 1365-1-.05(c), APPLICATIONS FOR LICENSURE WILL BE ACCEPTED THROUGHOUT THE YEAR AND FILES WHICH ARE COMPLETED ON OR BEFORE THE 30TH DAY PRIOR TO THE MEETING WILL ORDINARILY BE PROCESSED AT THE NEXT BOARD MEETING SCHEDULED.

Below is an explanation of items requested to be submitted in the checklist. When reviewing the checklist, refer to this section if you need clarification.

1. Read the enclosed rules and law carefully to determine if you are qualified.

2. Fill out the application form completely. Application must be signed and notarized. Incomplete forms or un-notarized forms will be returned thus delaying the application process.

3. FEES. Check or money order is to be made payable to the Board for Social Work in the amount indicated according to the method under which you are applying. The fee amount being collected with the application includes the state fee of ten dollars ($10) which will be refunded only in the event that your application is denied, and upon written request. THE APPLICATION FEE IS NONREFUNDABLE.

4. PHOTOGRAPH. Submit a recent (within the last twelve (12) months) passport size photograph which has been signed by the applicant and stapled to the appropriate area in the application.

5. TRANSCRIPT. Must be sent to the board directly from the institution. Please instruct the institution to indicate any name change since completion of course work.

6. Criminal Background Check required as of June 1, 2006. **Click here** for instructions.

7. Send your application, fees and supporting materials to:

   Tennessee Board of Social Worker Certification and Licensure
   227 French Landing, suite 300
   Heritage Place MetroCenter
   Nashville, TN 37243

GENERAL INFORMATION

Individuals who do not qualify for licensure at this time are encouraged to complete deficient requirements if you intend to practice as a social worker in Tennessee.

It is the applicant's responsibility to keep the board notified whenever a change of name or mailing address occurs. Such notification must be in writing and you must reference your profession and the board in your correspondence. A request for name change must be notarized and state the reason for the change, i.e., marriage, divorce, etc.

Every effort is made to keep you informed, in writing, of the status of your application and to process your application in a timely, efficient manner. Inquiries regarding the status of a file will be responded to in writing.

LICENSURE PROCESS

The following steps outline the licensure process, in sequence.

1. File application with board.

2. Review of application by the administrative office. A deficiency letter or administratively approved letter will be mailed to applicant.

3. Board ratification, if application is complete, at next scheduled Board meeting.

CHECK LIST FOR CERTIFIED MASTER SOCIAL WORKER

_____ COMPLETED/NOTARIZED APPLICATION

_____ FEES $110.00

_____ PHOTOGRAPH PASSPORT SIZE SIGNED

_____ TRANSCRIPTS

_____ MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

_____ CRIMINAL BACKGROUND CHECK REQUIRED AS OF JUNE 1, 2006 **CLICK HERE** FOR INSTRUCTIONS

WHEN DEEMED ELIGIBLE, LICENSE WILL BE MAILED WITHIN TWO (2) WEEKS.

40-001- $100
40-006- $ 10
$110

CERTIFIED MASTER SOCIAL WORKER APPLICATION

I hereby make application for a Master Social Worker in the State of Tennessee and submit the following facts with the required supportive documents and fee(s):

Given/M.I./Last [_____] [____] [_____]

Street Address [_____]

City/State/Zip [_____] [_____] [_____]

Home Phone [____ - _____ - _____] Office Phone [___ - ____ - _____]

Social Security No. [_____ - _____ - _____] *Race [_____] *Sex [_____]

Birthdate [_____/_____/_____] Name on Birth Certificate [_____]

U.S. Citizen: _____ Place of Birth [_____]

Name of College/University/School of Social Work where graduate degree was granted:

[_____]

Street Address
[_____]

City/State/Zip [_____] [_____] [_____]

Degree Received [_____] Date Received [_____]_____]_____]

If you are deemed eligible, how would you prefer your name on your license?

Given Name (_____)

Middle Initial (_____)

Last Name (_____)

*Optional -(For Statistical Purposes Only)

PROFESSIONAL EMPLOYMENT

Current Employer [_____]

Street Address [_____] County [_____]

City/State/Zip [_____] [_____] [_____]

Dates [_____/_____/_____ to _____/_____/_____]

Job Title [_____] Type of Position [_____]

Full Time [_____] Part Time [_____] Not working in profession [_____]

Supervisor's Name [_____] Educational Degree [_____]

Major Responsibilities _____

_____

_____

_____ _____

Applicant's Name Social Security Number

Fill out this section in the presence of a notary public and attach it to the completed application.

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.

For the purpose of these questions, the following phrases or words have the following meanings:

1. "Ability to practice Social Work" is to be construed to include all of the following:

    a. The cognitive capacity to make appropriate diagnosis or evaluation, exercise reasoned judgments, to learn, and keep abreast of developments in the field of social work.

    b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devises, such as voice amplifiers.

2. "Medical Condition" includes physiological, mental or psychological disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addition, and alcoholism.

3. "Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction as well as those used illegally.

4. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	YES	OR	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice social work with reasonable skill and safety:	_____		_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____		_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? *(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)*	_____		_____
2. Do you currently use chemical substances?	_____		_____
a. If yes, do they in any way limit or impair your ability to practice social work with reasonable skill and safety?	_____		_____
3. Are you currently engaged in the illegal use of controlled substance?	_____		_____
a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____		_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____		_____
5. If you have ever held or applied for a license or certificate to practice social work in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____		_____

QUESTIONS (CONTINUED): YES OR NO

6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? _____ _____

7. Have you ever failed a Social Work Licensure Examination? _____ _____

8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation? _____ _____

9. Have you ever been rejected or censured by a professional association? _____ _____

10. In relation to the performance of your professional services in any profession: _____ _____

    a. Have you ever had a final judgment rendered <u>against</u> you? _____ _____

    b. Have you ever had settlement of any legal action rendered <u>against</u> you? _____ _____

    c. Are there any legal actions pending <u>against</u> you or to which you are a party? _____ _____

11. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____ _____

PLACE PHOTO HERE
APPLICANT MUST SIGN
BACK OF PHOTO

AFFIDAVIT OF APPLICANT
APPLICANT'S CONSENT AND RELEASE

In applying for licensure in the State of Tennessee, I HEREBY:

AUTHORIZE THE BOARD, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competency, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

CONSENT TO THE RELEASE of such information.

RELEASE FROM LIABILITY the board, its staff, and all their representatives for their acts performed and statements made in good faith and without malice in connection with evaluation my application, my credentials, and my qualification.

ACKNOWLEDGE THAT I, as an applicant for certification or licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubt about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN MY APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE OF APPLICANT DATE

In the state of _____, and the county of _____, being duly sworn and identified as the person referred to in this application for a license to practice as a social worker in the State of Tennessee, he/she attests to the truth of each statement made in said application. He/she further swears that he/she has read and understands that the law and the rules and regulations, which were enclosed in the application packet, and agrees to abide by them while in practice in the State of Tennessee and acknowledged said instrument by him/her executed, to be his/her free act and deed.

_____
Signature of Notary

NOTARY SEAL:

Sworn to before me this _____ day of _____,_____.

My Commission Expires _____

SB/G3015146

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWARD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider to</u>:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records</u>.**

✓CHECKLIST

Before you mail your questionnaire:

Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER:_____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(____)_____ **(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.
1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:
1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date: _____

(Signature of Provider)
YB/G6019027/RTK-ms.70